STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED	
			B. WING		02/12/2013	
				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R		TECHNOLOGY DR		
CROWN	POINTE OF CARM	1EL	CARMEL, IN 46032			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	·	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
R0000						
	This visit was for a State Residential Licensure survey. Survey dates: February 11 and 12,		R0000	Submission of this Plan of Correction does not constitute admission to or an agreemen with facts alleged on the surv	t	
	2013			report.		
	Facility number Provider number: AIM number: Survey team: Janet Stanton Coordinator Michelle Hoste	oer: 012309 N/A , R.NTeam		Submission of this Plan of Correction does not constitute Admission or an agreement be the provider of the truth of facilities alleged or corrections set fort the statement of deficiencies.	y ets	
	Census bed ty Residential3 Total30	•		The Plan of Correction is prepared and Submitted because of State and Federal law.	ause	
	accordance w Quality Review	ndings are cited in ith 410 IAC 16.2. v completed by Tammy February 19, 2013.		Please accept this Plan of Correction as our credible allegation of compliance		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

State Form Event ID: R9WI11 Facility ID: 012309 If continuation sheet Page 1 of 42

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/27/2013 FORM APPROVED OMB NO. 0938-0391

	F OF DEFICIENCIES OF CORRECTION	[X1] PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING B. WING	00	COM 02/	IE SURVEY IPLETED 12/2013		
CROWNF	ROVIDER OR SUPPLIER	EL	STREET ADDRESS, CITY, STATE, ZIP CODE 11610 TECHNOLOGY DR CARMEL, IN 46032					
	SUMMARY S (EACH DEFICIEN				ECTION DULD BE PROPRIATE	(X5) COMPLETION DATE		

State Form Event ID: R9WI11 Facility ID: 012309 If continuation sheet Page 2 of 42

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
			B. WING			02/12/	2013
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				TECHNOLOGY DR		
CROWN	POINTE OF CARME	ΞL			EL, IN 46032		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R0214	410 IAC 16.2-5-2						
	Evaluation - Defic	<u> </u>					
	· •	of the individual needs of					
		all be initiated prior to all be updated at least					
		upon a known substantial					
		ident 's condition, or more					
	often at the reside	ent ' s or facility ' s request.					
		shall evaluate the nursing					
	needs of the resid						
		view and record	R02	14	1.The physician of resident #		02/28/2013
		lity failed to evaluate			was notified of the complaint o	Ť	
	the needs of 2 residents for issues of				arm pain and orders followed. The physician of resident #50		
	continued arm pain and weight gain,				was notified of the weight		
	in a sample of 8 residents reviewed.				changes and new orders were		
	[Residents #25	and #50]			followed.		
					2.No other residents were		
	Findings includ	e:			identified as having a substant		
	_				change in condition, warranting evaluation by a licensed nurse	-	
	1. The clinical	record for Resident			residents with who undergo a	. All	
	#25 was review	ved on 2/12/13 at			substantial change in condition	า	
	10:00 A.M. Dia	agnoses included, but			could be affected, thus, the		
		d to, congestive heart			following corrective actions we	ere	
		clerotic heart disease,			taken. 3.All licensed nurses and QN	1Λε	
	•	e renal failure, and			were addressed in regard to	ni/13	
	chest pain.				notification of the licensed nurs	se	
	Seet Panin				should the resident voice a		
	An "Interdiscipl	inary Progress Notes"			change in condition or the QM		
	-	2/12 at 7:45 A.M.,			observe a situation indicative of		
	-	t in to awake [name of			resident change in condition. The licensed nurse is then response		
		eakfast. Stated that			to evaluate and to make	שוטוכ	
	_	hurting" The entry			necessary notification and/or		
		Q.M.A. (Qualified			seek physician evaluation and		
	,	•			treatment, as warratned. The 2		
		e) #4. A subsequent			hour report sheet will be review	wed	
	•	.M., signed by the			and initialed by the DON or designee daily on regularly		
		ndicated "Went in to			scheduled days ongoing to		
	ask if she was	coming out for lunch.			contraction days origining to		

State Form Event ID: R9WI11 Facility ID: 012309 If continuation sheet Page 3 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			B. WING		02/12/2013
NAME OF F	ROVIDER OR SUPPLIER	<u> </u>		ET ADDRESS, CITY, STATE, ZIP CODE	
				0 TECHNOLOGY DR	
CROWN	POINTE OF CARM	EL	CAR	MEL, IN 46032	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE	E COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	She stated that	t she didn't feel well"		ensure all changes in condit	ion
				are addressed appropriately. Upon review,	the
	A progress not	e dated 9/3/12 at 7:00		DON or designee will ensure	
	A.M., signed by	y Q.M.A. #4, indicated		proper assessment has bee	
	"Stayed in bed	for A.M. Complained		completed for changes in	
	pain in arms hu	urting. She refused to		condition and the physician	will be
	come out for b	reakfast so sent in a		notified accordingly.	
	tray" A note	on 9/3/12 at 12:00		4.As a means of quality assurance the DON or design	inee
	P.M., signed by	y Q.M.A. #4, indicated		will complete the above design	•
	"Went in to get her for lunch and she			monitoring ongoing on a dai	
	was crying saying that her arms were			basis on regularly scheduled	l days
	hurting her bad and she had trouble			of work. Should a deficient	
	getting dressed and to the bathroom,			practice be observed, immed corrective action will be take	
		er to the restroom and		Additionally, the Administrate	
	also down to lu			designee will monitor and sign	
				on the 24 hour report sheets	
	A progress not	e dated 9/4/12 at 10:00		monthly ongoing. Based upo	
		y Q.M.A. #4, indicated		monitoring, the plan of corre	
		ake [resident's name]		will be revised accordingly, i warranted	I
		She complained of		warranted	
		ns. She refused to			
	come out"	is. One relused to			
	Come out				
	There was no	documentation that the			
	resident's arm				
		•			
	evaluated off a	ny of these 3 days.			
	There were no	subsequent progress			
		o arm pain until 11/6/12			
		an entry, signed by LPN			
		Resident complained of			
		•			
	severe pain to right arm/shoulder 'everywhere'. Resident called own				
		spoke to M.D. Order			
	received for X-	Ray: right shoulder,			

State Form Event ID: R9WI11 Facility ID: 012309 If continuation sheet Page 4 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPL	ETED
			B. WIN			02/12/	2013
			B. WII		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹		1	ECHNOLOGY DR		
CROWN	POINTE OF CARM	FI			EL, IN 46032		
			_	<u> </u>	, 11 10002		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	``	ICY MUST BE PRECEDED BY FULL	CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	humerus, elbo	w, ulna, radius"					
	recapitulation I included, but w (as needed) m 10/325 (a pain every 8 hours in Nitrostat (a chamg. as needed In an interview conference on LPN #5 indicat any arm pain is but did remem November. She have to review more information.	during the daily 2/12/13 at 1:20 P.M., red she could not recall assues in September, ber the issue in the indicated she would the clinical record for					
		ocumentation related in of the resident's arm iber, 2012.					
	Resident #50 v 2/11/13 at 12:2 was originally a on 3/27/12 with included, but w hypertension, of failure, morbid	clinical record for was reviewed on 25 P.M. The resident admitted to the facility in diagnoses that were not limited to, congestive heart obesity, and diabetes. was discharged to a					

State Form Event ID: R9WI11 Facility ID: 012309 If continuation sheet Page 5 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIP	LE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIHLDBY	2	00	COMPL	ETED
			A. BUILDING	ı		02/12/	/2013
			B. WING	DEET A	DDDESS CITY STATE 710 CODE	I	
NAME OF P	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
CDOMAN	POINTE OF CARM	EI			ECHNOLOGY DR		
CROWN	- OINTE OF CARM	EL		VICTIVIE	EL, IN 46032		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREF	IX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TA	G	DEFICIENCY)		DATE
	skilled nursing	facility on 2/8/13.					
	The resident's	weights were					
	documented a	_					
	May, 201228						
	•						
	June, 201228						
	July, 201228						
	_	-306 A note added					
		ght indicated "Dr.					
	[name] aware.						
	August, 2012						
	September, 20)12315					
	October, 2012	317					
	November, 20						
	December, 20						
	January, 2013						
	Tanuary, 2013	0 <u>2</u> I					
	Λ nrogross = -1	to from the Nurse					
		te from the Nurse					
	•	ated 8/23/12, indicated					
	•	oday. Evaluated					
	-	ght gain, increased					
		xtremities: 1+ pitting					
	edema to knee	e Start Lasix"					
	Other subsequ	ent evaluations of the					
	•	ght gain by the facility or					
	_	oner were not found.					
	TAULSC I TAULILL	oner were not lound.					
	In an interview	on 2/12/12 at 1:25					
		on 2/12/13 at 1:25					
	·	indicated the 8/23/12					
		Nurse Practitioner was					
	the only docun	nentation she could find					
	related to the r	esident's weight gain.					
							İ

State Form Event ID: R9WI11 Facility ID: 012309 If continuation sheet Page 6 of 42

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/27/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING B. WING	00	COMPLETED 02/12/2013			
CROWNI	ROVIDER OR SUPPLIER	EL	STREET ADDRESS, CITY, STATE, ZIP CODE 11610 TECHNOLOGY DR CARMEL, IN 46032					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	_		

State Form Event ID: R9WI11 Facility ID: 012309 If continuation sheet Page 7 of 42

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
					02/12/2013
			B. WING	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER				
000044	OLVITE OF OADA	- ,		TECHNOLOGY DR	
CROWNE	POINTE OF CARMI	EL	CARIMI	EL, IN 46032	
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
R0217	410 IAC 16.2-5-2	(e)(1-5)			
	Evaluation - Defic	ciency			
	(e) Following com	pletion of an evaluation,			
	the facility, using	appropriately trained staff			
	members, shall id	lentify and document the			
	services to be pro	ovided by the facility, as			
	follows:				
	` '	offered to the individual			
		appropriate to the:			
	(A) scope;				
	(B) frequency;				
	(C) need; and(D) preference;of the resident.(2) The services offered shall be reviewed				
	and revised as appropriate and discussed by				
	•	acility as needs or desires			
		e facility or the resident			
	may request a se	<u> </u>			
		oon service plan shall be			
		by the resident, and a			
	copy of the service	e plan shall be given to the			
	resident upon req	uest.			
	(4) No identification	on and documentation of			
	services provided	is needed if evaluations			
	•	e initial evaluation indicate			
	no need for a cha	_			
	` '	on of medications or the			
	-	ential nursing services, or			
		a licensed nurse shall be			
		ication and documentation			
	of the services to	•	D0217	1	00/00/0010
	Based on recor		R0217	1. The services plans of	02/28/2013
	•	acility failed to address		residents #13, 27 and 25 were reviewed and updated to include	
	current issues	for 3 out of 8 residents		current issues and intervention	•
	reviewed for se	ervice plans in a		2.All residents have the	13.
	sample of 8. (R	Resident # 13, Resident		potential to be affected. All	
		-		residents will have their service	e
	#27, and Resident #25)			plans reviewed and updated to	•
	Finalina: - ! ! !			ensure all current issues and	
	Findings includ	e.		interventions are addressed.	

State Form Event ID: R9WI11 Facility ID: 012309 If continuation sheet Page 8 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITE	LDDIC	00	COMPL	ETED
				LDING		02/12/	2013
			B. WIN				
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
					ΓECHNOLOGY DR		
CROWN	POINTE OF CARM	EL		CARME	EL, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROWING DEAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
					3.The DON or designee will		
	1 The eliminal	record for Decident #12			review and update all service		
		record for Resident #13			plans on a quarterly basis and	as	
		on 2/11/13 at 10:30			needed with changes. The DC		
	A.M. Diagnose	es included, but were			or designee will complete an		
	not limited to,	end stage congestive			ongoing audit on a monthly ba	sis	
		igh blood pressure,			of at least three (3) service		
		n, benign prostatic			plans to ensure all service pla		
		d osteoarthritis.			are updated with current issue	S	
		น บรเบบสานทานธ.			and interventions.		
					4.As a means of quality		
	The clinical record indicated the				assurance the DON or design		
	resident had di	ifficulty with urination			will complete the above descri		
	and had a fole	y placed by his			monitoring ongoing on a mont		
	physician on 1	1/12/2012.			basis. Should a deficient pract	ice	
					be observed, immediate corrective action will be taken.		
	The decument	titled "Level of Service			The Administrator will monitor		
					and sign off on the monitoring		
		valuation" indicated on			tools monthly ongoing. The pla	an	
	November 12,	2012 the resident			of correction will be revised	411	
	"Needs assis	stance daily to manage			accordingly, and number of au	dits	
	catheter"				increased or decreased, as		
					warranted.		
	The document	titled "Evaluation of					
		Plan for Resident" was					
		er 11, 2012, with the					
	most recent up	odate December 10,					
	2012. The dod	cument did not indicate					
	what type of se	ervice they were					
		e resident related to the					
	ı ·	g a Foley catheter.					
	i resident navint	g a roley calleter.					
	.	04045 + 5.55					
		on 2/12/13 at 2:30					
	P.M., the Direct	ctor of Nursing					
	indicated the	"Level of Service					
	Assessment/E	valuation" document					
		rvice plan but how they					
		-					
	aeciaea wnich	level of care the					

State Form Event ID: R9WI11 Facility ID: 012309 If continuation sheet Page 9 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MI	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIIII	DDIC	00	COMPL	ETED
			A. BUII		-	02/12/	2013
			B. WIN				
NAME OF F	ROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
00014/1		- .			FECHNOLOGY DR		
CROWN	POINTE OF CARM	EL		CARIME	EL, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	Y FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)			DATE		
	resident neede	ed. She indicated the					
	Evaluation of N	Needs/Service Plan was					
		they used as their					
		She indicated there was					
	nothing on the service plan about the resident's Foley.						
	0	and for Decide 1907					
		record for Resident #27					
		on 2/12/13 at 9:45 A.M.					
	_	luded, but were not					
	limited to, early	y congestive heart					
	failure, history of colon cancer and						
	diverticulitis, de	epression, psychotic					
		sided heart failure and					
		lure. The resident was					
	admitted on 6/3						
		0/2011.					
	The decument	titled "Level of Service					
		valuation" indicated on					
	· ·	the resident "Needs					
	assistance dai	ly with colostomy					
	care"						
	The document	titled "Evaluation of					
	Needs/Service	Plan" was dated July					
		the most recent					
		y 8, 2013. The					
	· •	not indicate what type					
		• •					
	·	were providing to the					
		d to the resident having					
	a colostomy.						
	In an interview	on 2/12/13 at 2:32					
	P.M., the Direct	ctor of Nursing					
		"Level of Service					
							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPL	ETED
			A. BUII			02/12/	2013
			B. WIN		DDDEGG CITY CTATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP CODE		
0001441	00 04 DA				FECHNOLOGY DR		
CROWN	POINTE OF CARM	EL		CARME	EL, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	D PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Assessment/E	valuation" document					
	was not the se	rvice plan but how they					
		level of care the					
		ed. She indicated the					
		Needs/Service Plan"					
		nent they used as their					
	•	he indicated there was					
	_	service plan about the					
	resident's colo	stomy.					
	In an intervi	iew during the initial					
	tour on 2/11/12	2 at 10:30 A.M., LPN #5					
	indicated Resid	dent #25 was receiving					
	contracted ser	•					
		pational Therapy,					
	· ·	· · ·					
	_	g, and Home Health					
	Aide.						
	The clinical red	cord for Resident #25					
	was reviewed	on 2/12/13 at 10:00					
	A.M. Diagnose	es included, but were					
	not limited to, o						
	-	the lower legs, obesity,					
		lisc disease, overactive					
	_						
	bladder, and fa	iligue.					
	-	y Progress Notes					
		ed the resident had					
	been found on	the floor on the					
	following dates	s:					
	11/29/12 at 7·1	15 A.M"heard					
		from her room she					
	yennig coning	HOIH HEI HOUHL SHE					

State Form Event ID: R9WI11 Facility ID: 012309 If continuation sheet Page 11 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			B. WING		02/12/2013
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER	L		TECHNOLOGY DR	
CROWN	POINTE OF CARM	FI		EL, IN 46032	
				T	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	was on the floo				
		terically about her			
	blood sugar'				
	12/2/12 at 4:00	A.M"Staff answered			
	call light and fo	ound resident in a			
	sitting position	on the floor with her			
	back to her bed	d facing her window.			
	Resident state	d she rolled out of bed.			
	Resident right	knee had rug burn from			
	the grip tape o	•			
	12/8/12 at 6:15 A.M"Came into the				
	building seen residents call light going				
	_	to the resident's room			
	and she was o				
		A.M" walked into			
		noticed she was on the			
		d. Resident stated			
	that she slid ou				
		5 P.M" Walked			
		o her room noticed she			
		or, she stated she			
	slipped on the				
	1/23/13 at 5:00	P.M"Resident			
	stated she slip	ped and felled [sic] in			
	bathroom"				
	1/26/13 at 12:2	0 P.M"Resident			
		trying to use the			
		slipped and felled [sic]			
		r on her buttocks, she			
		c] her left shin"			
		io.: o			
	On 2/12/13 at /	1:20 P.M., LPN #5			
		n titled "Level of			
	· •				
		sment/Evaluation,"			
	dated 7/26 and	11/12/12. She			

State Form Event ID: R9WI11 Facility ID: 012309 If continuation sheet Page 12 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			B. WING		02/12/2013
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER	t		TECHNOLOGY DR	
CROWN	POINTE OF CARM	FI		EL, IN 46032	
				T	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		vas the most recent			
		ne resident, and was			
	also used as th	ne Service Plan.			
	The form, whic	h used a numerical			
	scoring system	to document physical			
		lities, included the			
	following for Re				
	JUDGMFNT	Decisions are poor,			
		g and supervision in			
		nizing and correcting			
	daily routines.	lizing and correcting			
	•	Descripes sons 7			
		SRequires care 7			
	_	as well as supervision.			
	•	an five hours during an			
	eight-hour peri				
	BLADDER CO	NTROLNeeds			
	assistance dail	y to manage catheter			
	or sheath chan	ges, urinary ostomy,			
	incontinency of	r dribbling.			
		in only get around with			
		nce or another person			
	_	d outside. Not safe to			
		e. needs constant			
		dby assistance inside			
	_	•			
		address safety. Does			
	not have requi	•			
	endurance to υ	ise mechanical aids."			
		ning on the form			
	related to the c	contracted services for			
	therapy, skilled	I and Home Health			
	aide; and had i	not been updated to			
		sidents' multiple falls			
		•			

State Form Event ID: R9WI11 Facility ID: 012309 If continuation sheet Page 13 of 42

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/27/2013 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER:	A. BUILDING B. WING	00	COMPLETED 02/12/2013			
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE				
	POINTE OF CARME		11610 TECHNOLOGY DR CARMEL, IN 46032					
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
PREFIX	(EACH DEFICIENC REGULATORY OR	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE			

State Form Event ID: R9WI11 Facility ID: 012309 If continuation sheet Page 14 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) Da		(X3) DATE	DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріп	LDING	00	COMPL	ETED
			B. WIN			02/12/	2013
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				TECHNOLOGY DR		
CROWNI	POINTE OF CARMI	=I			EL, IN 46032		
CINOVINI	OINTE OF CARWII	<u></u>		CAINIL			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R0243	410 IAC 16.2-5-4						
	Health Services -						
	(3) The individual administering the						
	medication shall of						
		the individual 's medication					
	(A) time;	cords that indicate the:					
	• •	cation or treatment;					
	(C) dosage (if app						
	(D) name or initia						
	· ·	drug or treatment.					
	Based on observation, record review and interview, the facility failed to give a medication as ordered by the		R02	243	1.The physician and		02/28/2013
				_	responsible party of Resident		
					#29 were notified of the omiss	ion.	
		_			The resident incurred no nega	tive	
	physician for 1				outcome.		
		edication errors in a			2.All residents receiving		
	sample of 8. (R	Resident #20)			medications have the potentia	l to	
					be affected. All MARs were		
	Findings includ	le:			reviewed to ensure medication	IS	
					were documented as administered as ordered. No		
	The medication	n pass was completed			other concerns were noted.		
		2, 2013 with QMA #4			3.All nurses and QMA's will	ne	
	•	ication Aid) at 12:30			in-serviced on the facility's pol		
	•	ication Aid) at 12.30			on medication administration.		
	P.M.				DON or designee will complete	е	
					medication administration		
	QMA #4 gave r	medications to			observations twice weekly for		
	Resident #20 o	on 2/12/13 at 8:45 A.M.			one month, then weekly for on		
	The medication	ns she passed were as			month, then monthly ongoing t		
	follows: Lisinon	oril 20 mg (milligrams)			ensure medication administrat		
	•	• • • • •			is completed per facility policy.	•	
	one tablet and Pantazoprole 20 mg one tablet. She asked the resident at				4.As a means of quality assurance the DON or designed	26	
					will complete the above descri		
		needed anything for			monitoring ongoing on a mont		
	pain and the re	sident stated no.			basis. Should a deficient pract	•	
					be observed, immediate		
	The physician's	s orders for			corrective action will be taken.		
	medications for	r Resident #20 were			The Administrator or designed		
	reviewed on 2/	12/13 at 1:30 P.M.			will monitor and sign off on the	;	

State Form Event ID: R9WI11 Facility ID: 012309 If continuation sheet Page 15 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPL	ETED
			B. WIN			02/12/	2013
			B. WIIV		ADDRESS CITY STATE ZID CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
ODOMAN		E.			FECHNOLOGY DR		
CROWN	POINTE OF CARM	EL		CARIVIE	EL, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	The physician's	s orders indicated the			monitoring tools ongoing. Bas	ed	
		cations were to be			upon the findings, the plan of		
					correction will be revised		
	given at 8:00 A.M. Lisinopril 20 mg one tablet daily by mouth, Pantazoprole 20 mg one tablet daily				accordingly, if warranted.		
	•	anol 0.1% one drop in					
		, Neurontin 400 mg one					
	capsule twice	daily by mouth.					
	In an interview	with the Director of					
	Nursing (DON)) on 2/12/13 at 1:40					
		cated all of Resident					
	•	ons would be passed					
		e allotted. She indicated					
	_						
		ne is the resident					
	-	rops in her room while					
	_	ecliner. The Medication					
	Administration	Record for February					
	for Resident #2	20 was requested at					
	this time.	•					
	The DON prov	ided the MAR for					
	·	for Resident #20. The					
	•						
		r the 8 a.m. time slot for					
	Neurontin 400	mg were blank.					
	In an interview	with the DON on					
	2/12/13 at 1:45	5 P.M., she indicated					
	the Neurontin 400 mg had not been						
	given.	5					
	9.70						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETE			ETED	
			B. WIN			02/12/	2013
			D. ((1)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			l	TECHNOLOGY DR		
CROWNE	POINTE OF CARME	EL			EL, IN 46032		
					,		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG		LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
R0246	410 IAC 16.2-5-4	,		IAG			DATE
NU240	Health Services -	` '` '					
		ons may be administered					
		dication aide (QMA) only					
		n by a licensed nurse or					
	physician. The QI						
	appropriate author						
		a PRN medication. All					
		urse or physician not on the orization to administer					
	•	cumented in the nursing					
		he time and date of the					
	contact.						
	Based on interview and record		R0246		1.Resident #25, #50, #27 we	ere	02/28/2013
	review, the faci	lity failed to ensure			affected. PRN medications were		
		Medication Aide			administered as ordered,		
		cted a licensed nurse			although not authorized by the		
	to obtain autho				licensed nurse. The involved unlicensed staff has been		
		PRN (as needed)			addressed and re-educated.		
	•	nd documented time			2.All residents receiving PRI	١	
	•	Ill contacts in the			medications have the potentia		
		This deficiency			be affected. All nurses and		
		residents identified as			QMA's will be in-serviced on the	ne	
					facility's PRN medication administration policy, including		
	receiving PRN				receiving appropriate	J	
		y facility nursing			authorization for each		
	•	sample of 8 residents.			administration of a PRN		
	[Residents #25	i, #27, and #50]			medication.		
					3.QMAs are to notify a		
	Findings includ	e:			nurse before administering any	y	
					PRN medication for approval. The DON or designee will		
	1. The clinical	record for Resident			document all authorizations gi	ven	
	#25 was review	ved on 2/12/13 at			for administration of PRN		
	10:00 A.M. Dia	agnoses included, but			medications via use of a log. T	he	
	were not limited	d to, diabetes with			DON or designee will then che	eck	
		ulcer, cellulitis, and			the medical record to ensure		
	•	ck pain, obesity, and			accuracy of the documentation	1	
	degenerative d	•			for administration of the PRN medication administration and		
			1		I modication administration and		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DDIG	00	COMPL	ETED
			A. BUII			02/12/	2013
			B. WIN		A DDDDGG CYTY CTATE GIR CODE		
NAME OF	PROVIDER OR SUPPLIE	ER		l	ADDRESS, CITY, STATE, ZIP CODE		
00014/14	DOINTE OF OAR	AC.			FECHNOLOGY DR		
CROWN	POINTE OF CARM	/IEL		CARME	EL, IN 46032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG	The MAR (Me Record) for Norder, dated 7 Hydrocodone medication) 7 one tablet every December 20 dosage was considered from the resident resident resident resident resident from the maximum to administered indicated by in the resident resi	edication Administration ovember, 2012 listed an 2/13/12, for APAP (a pain 5-750 mg. (milligrams) ery 8 hours PRN. The 12 MAR indicated the hanged on 12/11/12 to me three times a day er, 2012 MAR indicated eccived 12 doses of the on between 11/16 and doses were by a Q.M.A., as nitials on the front and AR. The initials were PN #5. documentation on the er clinical record notes Q.M.A. had contacted a er for authorization prioring the medication. er, 2012 MAR indicated eccived 16 doses of the on between 12/4 and doses were by a Q.M.A., as nitials on the front and AR. The initials were		TAG	co-sign accordingly when next on-site in the facility. 4. As a means of quality assurance the DON or design will complete the above descrimonitoring ongoing daily on regularly scheduled days of w. Should a deficient practice be observed, immediate correctivaction will be taken. The Administrator or designee will monitor and sign off on the monitoring tools monthly ongo Based upon the monitoring findings, the plan of correction be revised accordingly, if warranted.	ee ibed ork. re	DATE

State Form Event ID: R9WI11 Facility ID: 012309 If continuation sheet Page 18 of 42

NAME OF PROVIDER OR SUPPLIER CROWNPOINTE OF CARMEL (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (LEACH DEFICIENCY MUST BE PRECEDED BY PEUL TAG PROGRAMMENT OF DEFICIENCY MUST BE PRECEDED BY PEUL TAG PREGULATORY OR ISC IDENTIFYING INFORMATION) There was no documentation on the MAR or in other clinical record notes indicating the Q.M.A. had contacted a licensed nurse for authorization prior to administering the medication. 2. The closed clinical record for Resident #50 was reviewed on 2/11/13 at 12:25 PM. Diagnoses included, but were not limited to, hypertension, diabetes with neuropathy, lumbo-sacral intervertebral disc degeneration, lumbago, osteoarthritis, cognitive impairment, and depression. The February, 2013 physician order recapitulation sheet included orders for Athvan (an anti-depressant medication, also used for insomnia) 50 mg. at bedtime for sleep PRN. The October, 2012 MAR (Medication Administration Record) indicated the resident had received a dose of Ativan on 10/7/12. The dose was administered by a Q.M.A., as indicated by initials on the front and	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
NAME OF PROVIDER OR SUPPLIER CROWNPOINTE OF CARMEL (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY BILL. TAG RIGULATORY OR LSC IDENTIFYING INFORMATION) There was no documentation on the MAR or in other clinical record notes indicating the Q.M.A. had contacted a licensed nurse for authorization prior to administering the medication. 2. The closed clinical record for Resident #50 was reviewed on 2/11/1/3 at 12:25 PM. Diagnoses included, but were not limited to, hypertension, diabetes with neuropathy, lumbo-sacral intervertebral disc degeneration, lumbago, osteoarthritis, cognitive impairment, and depression. The February, 2013 physician order recapitulation sheet included orders for Ativan (an antianxiety medication) 0.5 mg. (milligrams) every 6 hours PRN; and Trazadone (an anti-depressant medication, also used for insomnia) 50 mg. at bedtime for sleep PRN. The October, 2012 MAR (Medication Administration Record) indicated the resident had received a dose of Ativan on 10/7/12. The dose was administered by a Q.M.A., as	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIIII	DING	00	COMPL	ETED
NAME OF PROVIDER OR SUPPLIER CROWNPOINTE OF CARMEL (X4) ID PREITX (LEACH DEFICIENCY MUST BE PRECIPED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) There was no documentation on the MAR or in other clinical record notes indicating the Q.M.A. had contacted a licensed nurse for authorization prior to administering the medication. 2. The closed clinical record for Resident #50 was reviewed on 2/11/13 at 12:25 PM. Diagnoses included, but were not limited to, hypertension, diabetes with neuropathy, lumbo-sacral intervertebral disc degeneration, lumbago, osteoarthritis, cognitive impairment, and depression. The February, 2013 physician order recapitulation sheet included orders for Ativan (an antianxiety medication) 0.5 mg, (milligrams) every 6 hours PRN; and Trazadone (an anti-depressant medication, also used for insomnia) 50 mg, at bedtime for sleep PRN. The October, 2012 MAR (Medication Administration Record) indicated the resident had received a dose of Ativan on 10/7/12. The dose was administered by a Q.M.A., as							02/12/	2013
ROWNPOINTE OF CARMEL CROWNPOINTE OF CARMEL SUMMARY STATEMENT OF DEFICIENCES PRETIX TAG There was no documentation on the MAR or in other clinical record notes indicating the Q.M.A. had contacted a licensed nurse for authorization prior to administering the medication. 2. The closed clinical record for Resident #50 was reviewed on 2/11/13 at 12:25 PM. Diagnoses included, but were not limited to, hypertension, diabetes with neuropathy, lumbo-sacral intervertebral disc degeneration, lumbago, osteoarthritis, cognitive impairment, and depression. The February, 2013 physician order recapitulation sheet included orders for Ativan (an antianxiety medication) 0.5 mg. (milligrams) every 6 hours PRN; and Trazadone (an anti-depressant medication, also used for insomnia) 50 mg. at bedtime for sleep PRN. The October, 2012 MAR (Medication Administration Record) indicated the resident had received a dose of Ativan on 10/7/12. The dose was administered by a Q.M.A., as				B. WIIN		ADDRESS CITY STATE ZIP CODE		
CARMEL, IN 46032 CARMEL, IN 46032 CARMEL CARMEL, IN 46032 CAR	NAME OF P	PROVIDER OR SUPPLIER	t .					
SUMMARY STATEMENT OF DEFICIENCIES PROVIDERS IT ALL OF COMPLETION PREFIX CEACH DEFICITINCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CROSS PAFE PERMEDIA CONTINUATION TAG CROSS PAFE PERMEDIA CONTINUATION DATE There was no documentation on the MAR or in other clinical record notes indicating the Q.M.A. had contacted a licensed nurse for authorization prior to administering the medication. 2. The closed clinical record for Resident #50 was reviewed on 2/11/13 at 12:25 PM. Diagnoses included, but were not limited to, hypertension, diabetes with neuropathy, lumbo-sacral intervertebral disc degeneration, lumbago, osteoarthritis, cognitive impairment, and depression. The February, 2013 physician order recapitulation sheet included orders for Ativan (an antianxiety medication) 0.5 mg. (milligrams) every 6 hours PRN; and Trazadone (an anti-depressant medication, also used for insomnia) 50 mg. at bedtime for sleep PRN. The October, 2012 MAR (Medication Administration Record) indicated the resident had received a dose of Ativan on 10/7/12. The dose was administered by a Q.M.A., as	CDOWNI		El					
PREFIX TAG RECULATORY OR LSC IDENTIFYING INFORMATION) There was no documentation on the MAR or in other clinical record notes indicating the Q.M.A. had contacted a licensed nurse for authorization prior to administering the medication. 2. The closed clinical record for Resident #50 was reviewed on 2/11/13 at 12:25 PM. Diagnoses included, but were not limited to, hypertension, diabetes with neuropathy, lumbo-sacral intervertebral disc degeneration, lumbago, osteoarthritis, cognitive impairment, and depression. The February, 2013 physician order recapitulation sheet included orders for Ativan (an antianxiety medication) 0.5 mg. (milligrams) every 6 hours PRN; and Trazadone (an anti-depressant medication, also used for insomnia) 50 mg. at bedtime for sleep PRN. The October, 2012 MAR (Medication Administration Record) indicated the resident had received a dose of Ativan on 107/12. The dose was administered by a Q.M.A., as	CROWN	FOINTE OF CARIVI			CARIVIL	L, IN 40032		
There was no documentation on the MAR or in other clinical record notes indicating the Q.M.A. had contacted a licensed nurse for authorization prior to administering the medication. 2. The closed clinical record for Resident #50 was reviewed on 2/11/13 at 12:25 PM. Diagnoses included, but were not limited to, hypertension, diabetes with neuropathy, lumbo-sacral intervertebral disc degeneration, lumbago, osteoarthritis, cognitive impairment, and depression. The February, 2013 physician order recapitulation sheet included orders for Ativan (an antianxiety medication) 0.5 mg. (milligrams) every 6 hours PRN; and Trazadone (an anti-depressant medication, also used for insomnia) 50 mg. at bedtime for sleep PRN. The October, 2012 MAR (Medication Administration Record) indicated the resident had received a dose of Ativan on 10/7/12. The dose was administered by a Q.M.A., as	(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
There was no documentation on the MAR or in other clinical record notes indicating the Q.M.A. had contacted a licensed nurse for authorization prior to administering the medication. 2. The closed clinical record for Resident #50 was reviewed on 2/11/13 at 12:25 PM. Diagnoses included, but were not limited to, hypertension, diabetes with neuropathy, lumbo-sacral intervertebral disc degeneration, lumbago, osteoarthritis, cognitive impairment, and depression. The February, 2013 physician order recapitulation sheet included orders for Ativan (an antianxiety medication) 0.5 mg. (milligrams) every 6 hours PRN; and Trazadone (an anti-depressant medication, also used for insomnia) 50 mg. at bedtime for sleep PRN. The October, 2012 MAR (Medication Administration Record) indicated the resident had received a dose of Ativan on 10/7/12. The dose was administered by a Q.M.A., as	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX		ΓE	COMPLETION
MAR or in other clinical record notes indicating the Q.M.A. had contacted a licensed nurse for authorization prior to administering the medication. 2. The closed clinical record for Resident #50 was reviewed on 2/11/13 at 12:25 PM. Diagnoses included, but were not limited to, hypertension, diabetes with neuropathy, lumbo-sacral intervertebral disc degeneration, lumbago, osteoarthritis, cognitive impairment, and depression. The February, 2013 physician order recapitulation sheet included orders for Ativan (an antianxiety medication) 0.5 mg. (milligrams) every 6 hours PRN; and Trazadone (an anti-depressant medication, also used for insomnia) 50 mg. at bedtime for sleep PRN. The October, 2012 MAR (Medication Administration Record) indicated the resident had received a dose of Ativan on 10/7/12. The dose was administered by a Q.M.A., as	TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
back of the MAR. The initials were identified by LPN #5.	IAG	There was no of MAR or in other indicating the Olicensed nurse to administerin. 2. The closed Resident #50 v 2/11/13 at 12:2 included, but whypertension, on europathy, lurintervertebral of lumbago, osteo impairment, and The February, recapitulation of for Ativan (and a 0.5 mg. (millign PRN; and Trazanti-depressant for insomnia) 5 sleep PRN. The October, 2 Administration resident had readministered by indicated by initiation of the MAR.	documentation on the er clinical record notes Q.M.A. had contacted a for authorization prior g the medication. clinical record for was reviewed on 25 PM. Diagnoses were not limited to, diabetes with mbo-sacral lisc degeneration, parthritis, cognitive and depression. 2013 physician order sheet included orders antianxiety medication) mans) every 6 hours adone (an at medication, also used to mg. at bedtime for eceived a dose of 12. The dose was y a Q.M.A., as itials on the front and AR. The initials were		IAG	DEPICIENCY)		DATE

State Form Event ID: R9WI11 Facility ID: 012309 If continuation sheet Page 19 of 42

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/12/2013
	PROVIDER OR SUPPLIEF		11610 7	ADDRESS, CITY, STATE, ZIP COE ECHNOLOGY DR EL, IN 46032	DE .
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ILD BE COMPLETION
	MAR or in othe indicating the Clicensed nurse	documentation on the er clinical record notes Q.M.A. had contacted a for authorization prior g the medication.			
	the resident ha Ativan on 12/9 doses were ad Q.M.A., as indi front and back	r, 2012 MAR indicated and received 2 doses of and 12/29/12. All ministered by a cated by initials on the of the MAR. The entified by LPN #5.			
	MAR or in othe indicating the Clicensed nurse	documentation on the er clinical record notes Q.M.A. had contacted a for authorization prior g the medication.			
	resident had re Ativan on 1/26. Trazadone on All doses were Q.M.A., as indi front and back	2013 MAR indicated the eceived 1 dose of 713, and 4 doses of 1/1, 2, 3, and 4, 2013. administered by a cated by initials on the of the MAR. The entified by LPN #5.			
	MAR or in othe indicating the 0 a licensed nurs	documentation on the er clinical record notes Q.M.A.s had contacted se for authorization stering the medication.			

State Form Event ID: R9WI11 Facility ID: 012309 If continuation sheet Page 20 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
			B. WIN			02/12/	2013
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ECHNOLOGY DR		
CROWN	POINTE OF CARM	EL	CARMEL, IN 46032				
(X4) ID	SUMMARYS	TATEMENT OF DEFICIENCIES	1	ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
TAG	3. The clinical #27 was review A.M. Diagnoso not limited to, of failure, history diverticulitis, do episodes, right acute renal fail admitted on 6/3. The Medication Record (MAR) a PRN (as nee Vicodin 5/325 every 6 hours a The box dated and 1/30 had in initials were ide of Nursing as 0 medication aid the MAR indication aid the MAR indication aid with the QMA's noted. There we or initials by the The nurses not and 1/30 did not indicating the 0 and received p PRN pain med 4. In an interview.	record for Resident wed on 2/12/13 at 9:45 es included, but were early congestive heart of colon cancer and epression, psychotic sided heart failure and ture. The resident was 3/2011. In Administration for January 2013 had eded) medication of mg one tablet by mouth as needed for pain. for 1/25, 1/28, 1/29 nitials in them and the entified by the Director QMA's (qualified) initials. The back of ated the medication that it was effective initials and time was no nurses signature ese entries. Ites for 1/25, 1/28, 1/29 of have any entries QMA had requested permission to give the		TAG	DEFICIENCY)		DATE

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/27/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
			A. BUILDING B. WING		02/12/2013	
				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R		TECHNOLOGY DR		
CDOWN	POINTE OF CARM	ΛΕI		EL, IN 46032		
CROWN	FOINTE OF CARI		CARIVII	EL, IN 40032		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	IATE CONTINUE	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	only licensed	nurse employed by the				
	facility. She in	ndicated the Q.M.A.s				
	would call her one time in the evening					
		P.M., and tell her who				
		ndy given PRN				
	-	o, and she would note it				
		ept. She indicated as				
		sed nurse, she was not				
	-					
		the Q.M.A.s call her				
		y needed to administer				
	a PRN medica	ation.				

State Form Event ID: R9WI11 Facility ID: 012309 If continuation sheet Page 22 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) D		(X3) DATE S	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING CO		COMPL	ETED	
			A. BUII B. WIN			02/12/	2013
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
CDOWNI		=1			FECHNOLOGY DR		
CROWN	POINTE OF CARMI	EL .	CARME		EL, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)		DATE
R0273	. ,						
		nal Services - Deficiency					
	(f) All food preparation and serving areas						
		in residents ' units) are					
		cordance with state and					
		nd safe food handling					
	standards, includi		Dog	72			02/20/2012
		rvation and record	R02	113	1. The sanitation solution was	5	02/28/2013
		ity failed ensure the			prepared upon arrival of the Dietary Manager. The dirty rag	10	
		chen equipment was			were removed from the sink. T		
	clean and sanit	tized, and failed to			grape jelly was disposed of. The		
	ensure food wa	as held at the proper			cracked eggs were disposed of		
	temperature for				The plastic bag of onions and		
		This deficit practice			green peppers was disposed of	of.	
		al to affect 30 of 30			The cooler has a thermostat of	n	
	•				the outside of it for monitoring		
	residents resid	ing in the facility.			the temperature. A thermome		
					was placed inside of the coole		
	Findings includ	e:			for monitoring the temperature		
					inside as well. The fan inside t	he	
	The initial tour	of the kitchen was			freezer was cleaned. The	rom	
	completed on 2	2/11/13 at 10 A.M.			Styrofoam cup was removed for the flour and disposed of. The	OIII	
	•	staff present in the			slicer was cleaned immediately	v	
		ime the tour began at			The pipe was adjusted to an	y .	
	10 A.M.	inc the tour began at			appropriate position.		
	IU A.W.				2.All residents have the		
					potential to be affected, thus the	ne	
		with the Director of			following corrective actions we		
	Nursing on 2/1	1/13 at 10 A.M., she			taken. The kitchen daily cleani		
	indicated the D	ietary Manager			schedule has been updated to		
	overslept and v	vould be in shortly. She			include cleaning and disinfecti	•	
	•	and the Activities			the slicer. The kitchen monthly	1	
		had been in charge of			cleaning schedule has been	_	
	breakfast for th	<u> </u>			updated to include cleaning the fan in the walk in freezer.	t	
	מו במעומפנ וטו נוו	e residents.			Administrative staff has		
	Desire at the 122 to	and the fall :			addressed necessary action to	be	
	•	nen tour, the following			taken in the absence of		
	was observed:				scheduled dietary staff, and		
					applicable personnel will be		

State Form Event ID: R9WI11 Facility ID: 012309 If continuation sheet Page 23 of 42

AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIER CROWNPOINTE OF CARMEL MAJ D SEMMARY STATEMENT OF DEPICIENCES TAG REACH DEPICIENCY MUST BE PRECEDED BY PULL TAG REACH DEPICENCY MUST BE PRECEDED BY PULL TAG There was no sanitation solution prepared. There were dry dirty rags sitting over the edge of the three compartment sink. There was a tub of grape jelly undated and unlabeled sitting out on one of the counters, it was warm to touch. There was a cooler beside the fryer area and inside of it there were approximately 18 stacks of eggs. It was noted two of the stacks of eggs had eggs with cracks in them, dried in place. There was an unsealed plastic bag of chopped onion and green peppers with moisture accumulated inside the bag. There was no thermometer inside to tell the environmental temperature. The walk in freezer had a fan that was covered with a dusty debris. There was a Styrofoam cup inside of the flour. There was a pipe coming out of the	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
NAME OF PROVIDER OR SUPPLIER CROWNPOINTE OF CARMEL TAG SUMMARY STATEMENT OF DEFICIENCES PRESENT TAG There was no sanitation solution prepared. There was a color beside the fryer area and inside of it there ware approximately 18 stacks of eggs had eggs with cracks in them, dried in place. There was an unsealed plastic bag of chopped onion and green peppers with moisture accumulated inside the bag. There was no thermometer inside to tell the environmental temperature. There was a Styrofoam cup inside of the flour. There was a Styrofoam cup inside of the flour. There was a Styrofoam cup inside of the flour. There was a Styrofoam cup inside of the flour. There was a Styrofoam cup inside of the flour. There was a Styrofoam cup inside of the flour. There was a Styrofoam cup inside of the flour. There was a Styrofoam cup inside of the flour. There was a Styrofoam cup inside of the flour. There was a Styrofoam cup inside of the flour. The meat shredder had dried pink debris on the cutting surface.	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIT	A DITH DING 00			COMPLETED	
STREET ADDRESS, CITY, STATE, ZIP CODE 11610 TECHNOLOGY DR CARMEL CX4 ID SUMMARY STATEMENT OF DEFICIENCIES PRIETY TAG There was no sanitation solution prepared. There were dry dirty rags sitting over the edge of the three compartment sink. There was a tub of grape jelly undated and unlabeled sitting out on one of the counters, it was warm to touch. There was a cooler beside the fryer area and inside of it there were approximately 18 stacks of eggs had eggs with cracks in them, dried in place. There was no unsealed plastic bag of chopped onion and green peppers with moisture accumulated inside the bag. There was no thermometer inside to tell the environmental temperature. The walk in freezer had a fan that was covered with a dusty debris. There was a Styrofoam cup inside of the flour. The meat shredder had dried pink debris on the cutting surface.							02/12/	2013	
CROWNPOINTE OF CARMEL IN A JUD SUMMARY STATEMENT OF DEPICIENCIES PREFIX TAG SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL TAG There was no sanitation solution prepared. There was no sanitation solution prepared. There was no sanitation solution prepared. There was a tub of grape jelly undated and unlabeled sitting out on one of the counters, it was warm to touch. There was a cooler beside the fryer area and inside of it there were approximately 18 stacks of eggs. It was noted two of the stacks of eggs had eggs with cracks in them, dried in place. There was an unsealed plastic bag of chopped onion and green peppers with moisture accumulated inside the bag. There was no thermometer inside to tell the environmental temperature. The walk in freezer had a fan that was covered with a dusty debris. There was a Styrofoam cup inside of the flour. The meat shredder had dried pink debris on the cutting surface.				B. WIN			\$2, 12,		
CROWNPOINTE OF CARMEL (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (RACH DEFICIENCY MIST BE PRECEDED BY FULL TAG REGULATORY OR IS CENDATIFYING INFORMATION) There was no sanitation solution prepared. There was no sanitation solution prepared. There was a tub of grape jelly undated and unlabeled sitting out on one of the counters, it was warm to touch. There was a cooler beside the fryer area and inside of it there were approximately 18 stacks of eggs. It was noted two of the stacks of eggs had eggs with cracks in them, dried in place. There was an unsealed plastic bag of chopped onion and green peppers with moisture accumulated inside the bag. There was no thermometer inside to tell the environmental temperature. The walk in freezer had a fan that was covered with a dusty debris. The meat shredder had dried pink debris on the cutting surface.	NAME OF I	PROVIDER OR SUPPLIE	2		STREET A	ADDRESS, CITY, STATE, ZIP CODE			
ID PRETEX GRACH DEFICENCY MUST BE PRECEDED BY BILL TAG REGULATORY OR ISE (DENTIFYING INFORMATION) There was no sanitation solution prepared. There was a tub of grape jelly undated and unlabeled sitting out on one of the counters, it was warm to touch. There was a cooler beside the fryer area and inside of it there were approximately 18 stacks of eggs. It was noted two of the stacks of eggs had eggs with cracks in them, dried in place. There was an unsealed plastic bag of chopped onion and green peppers with moisture accumulated inside the bag. There was no thermometer inside to tell the environmental temperature. The walk in freezer had a fan that was covered with a dusty debris. There was a Styrofoam cup inside of the flour. The meat shredder had dried pink debris on the cutting surface. The walk in greater had dried pink debris on the cutting surface. The walk in greater had dried pink debris on the cutting surface. The walk in greater had dried pink debris on the cutting surface. The walk in greater had dried pink debris on the cutting surface. The walk in greater had dried pink debris on the cutting surface. The walk in greater had dried pink debris on the cutting surface. The walk in greater had dried pink debris on the cutting surface. The walk in greater had dried pink debris on the cutting surface. The walk in greater had dried pink debris on the cutting surface. The walk in greater had dried pink debris on the cutting surface. The walk in greater had dried pink debris on the cutting surface. The walk in greater had dried pink debris on the cutting surface. The walk in greater had dried pink debris on the cutting surface. The walk in greater had dried pink debris on the cutting surface. The walk in greater had dried pink debris on the cutting surface. The walk in greater had dried pink debris on the cutting surface.	TALME OF I	NO TIDEN ON BUILDING			11610	TECHNOLOGY DR			
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There was no sanitation solution prepared. There was a different sink. There was a tub of grape jelly undated and unlabeled sitting out on one of the counters, it was warm to touch. There was a cooler beside the fryer area and inside of it there were approximately 18 stacks of eggs. It was noted two of the stacks of eggs had eggs with cracks in them, dried in place. There was an unsealed plastic bag of chopped onion and green peppers with moisture accumulated inside the bag. There was no thermometer inside to tell the environmental temperature. The walk in freezer had a fan that was covered with a dusty debris. The meat shredder had dried pink debris on the cutting surface.						PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		` ′	
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There were dry dirty rags sitting over the edge of the three compartment sink. There was a tub of grape jelly undated and unlabeled sitting out on one of the counters, it was warm to touch. There was a cooler beside the fryer area and inside of it there were approximately 18 stacks of eggs had eggs with cracks in them, dried in place. There was an unsealed plastic bag of chopped onion and green peppers with moisture accumulated inside the bag. There was no thermometer inside to tell the environmental temperature. The walk in freezer had a fan that was covered with a dusty debris. There was a Styrofoam cup inside of the flour. The meat shredder had dried pink debris on the cutting surface.	1710		<u> </u>	+	1710	trained appropriately with said		DATE	
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sink. There was a tub of grape jelly undated and unlabeled sitting out on one of the counters, it was warm to touch. There was a cooler beside the fryer area and inside of it there were approximately 18 stacks of eggs had eggs with cracks in them, dried in place. There was an unsealed plastic bag of chopped onion and green peppers with moisture accumulated inside the bag. There was no thermometer inside to tell the environmental temperature. The walk in freezer had a fan that was covered with a dusty debris. There was a Styrofoam cup inside of the flour. The meat shredder had dried pink debris on the cutting surface.						_	od		
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Inere was a tub of grape jelly undated and unlabeled sitting out on one of the counters, it was warm to touch. There was a cooler beside the fryer area and inside of it there were approximately 18 stacks of eggs. It was noted two of the stacks of eggs had eggs with cracks in them, dried in place. There was an unsealed plastic bag of chopped onion and green peppers with moisture accumulated inside the bag. There was no thermometer inside to tell the environmental temperature. The walk in freezer had a fan that was covered with a dusty debris. There was a Styrofoam cup inside of the flour. A.As a means of quality assurance the Dietary Manager or deside walk through of the kitchen which will include, but not be limited to checking the food slicer, walk in freezer fan, and proper sanitization bucket to ensure all tasks are being completed. This will be conducted at least three times weekly ongoing. The Dietary Manager or designee will sign at the bottom of each daily cleaning assignment sheet to verify that all tasks have been completed. The daily and monthly cleaning schedules will be reviewed and signed off monthly ongoing by the Administrator or designee.									
undated and unlabeled sitting out on one of the counters, it was warm to touch. There was a cooler beside the fryer area and inside of it there were approximately 18 stacks of eggs. It was noted two of the stacks of eggs had eggs with cracks in them, dried in place. There was an unsealed plastic bag of chopped onion and green peppers with moisture accumulated inside the bag. There was no thermometer inside to tell the environmental temperature. The walk in freezer had a fan that was covered with a dusty debris. There was a Styrofoam cup inside of the flour. The meat shredder had dried pink debris on the cutting surface.									
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the flour. The meat shredder had dried pink debris on the cutting surface.		was covered w	ith a dusty debris.						
the flour. The meat shredder had dried pink debris on the cutting surface.									
The meat shredder had dried pink debris on the cutting surface.		There was a S	tyrofoam cup inside of						
debris on the cutting surface.		the flour.							
debris on the cutting surface.									
debris on the cutting surface.		The meat shre	dder had dried nink						
		·							
There was a pipe coming out of the									
There was a pipe coming out of the									
		There was a pipe coming out of the							
walk-in refrigerator onto the floor lying		walk-in refriger	rator onto the floor lying						

State Form Event ID: R9WI11 Facility ID: 012309 If continuation sheet Page 24 of 42

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/27/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE : COMPL 02/12 /	ETED
	PROVIDER OR SUPPLIER		S. WINC	STREET A 11610 T	DDRESS, CITY, STATE, ZIP CODE ECHNOLOGY DR L, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	2/11/13 at 10:1 interview at that they usually proposed solution first the when she arrives the indicated the usually dated at fallen off. She clean rags that counters. The fryer was checking the gright side on the for it's proper to there was no the inside of the counties and squatted she was 40 degree indicated she usually degree indicated she usually cooking eggs for breaking, cooking eggs for breaking indicated she usually at the freezer and whose responsitions thought it was she also indicated for the scheduled for the solution of the scheduled for the solution of the solution of the scheduled for the solution of the solution	anager (DM) arrived on 7 A.M. During at time, she indicated epare sanitation ing in the morning es around 7:00 A.M. The tub of jelly was and the label must have indicated there were a staff use for sanitizing cooler besides the ked and she indicated the temperature by auge on the bottom e outside of the cooler emperature and that hermometer on the boler. She leaned over aying the temperature is currently. She issed eggs for all g and preparation of fast food. The DM and hot clean the fan in a was not certain sibility it was, she probably maintenance. In a was sick yon one to take her					

State Form Event ID: R9WI11 Facility ID: 012309 If continuation sheet Page 25 of 42

	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION OO	(X3) DATE SURVEY COMPLETED 02/12/2013
	PROVIDER OR SUPPLIER POINTE OF CARMEL	11610	ADDRESS, CITY, STATE, ZIP CODE FECHNOLOGY DR EL, IN 46032	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION
	On 2/11/13 at 12:40 P.M., the DM checked the food temperatures of the Salisbury steak, mashed potatoes and peas and carrots with a thermometer. She took the thermometer out of a pocket in the front of her apron. She pulled the thermometer out of it's protective sleeve. She then stuck it into the Salisbury steak. After obtaining a temperature, she removed the thermometer from the meat and wiped it off with a dry paper towel, and then stuck the thermometer into the mashed potatoes. After obtaining a temperature, she removed it from the food and again wiped with dry paper towel. She then stuck thermometer into the peas and carrots, wiped it with a dry paper towel, placed it into the protective sleeve and back into the pocket of her apron. The policies and cleaning lists were provided by the Administrator on 2/12/13 at 9:25 A.M. At that time, she indicated the thermometer should have been cleaned with an alcohol wipe. She also indicated they only had training for the actual kitchen staff as well as the Activity Director, but they did not have documentation indicating training for the Director of Nursing to work in the kitchen.			

State Form Event ID: R9WI11 Facility ID: 012309 If continuation sheet Page 26 of 42

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	00		E SURVEY PLETED	
			A. BUILDING B. WING		- 02/1	2/2013
	PROVIDER OR SUPPLIEI		11610 7	ADDRESS, CITY, STATE, ZIP C FECHNOLOGY DR EL, IN 46032	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	The policy for stated 11/12/08 necessary to discer after each of the policy for stated 11/12/08 "Sanitation be available in the all times 1. Embucket for food of the policy for Thermometers indicated, "T to ensure that (refrigerator/free products are at to prevent back Thermometers locate and place of the policy for Service Line dindicated, "1 sanitize dial face alcohol wipe. Furthermometer at the cleaning stated, "wk wk 5sweep indicated, "wk yk 5sweep indica	sanitizing the slicer 3 indicated, "It is lean and sanitize the th use" sanitation buckets 3 indicated, uckets must be to Dietary Department at aployees should make 1 If contact surfaces" Food & Equipment to dated 11/12/08 thermometers are used food storage units the ezers and food to proper temperatures terial growth1. to should be easy to the dated 11/12/08 thermometers on the dated 11/12/08 thermometer with				

State Form Event ID: R9WI11 Facility ID: 012309 If continuation sheet Page 27 of 42

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/27/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	INTERPRETABLE (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CC A. BUILDING B. WING	00	COM	E SURVEY PLETED 2/2013
NAME OF P	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP	CODE	
CROWNI	POINTE OF CARM	EL		FECHNOLOGY DR EL, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE

State Form Event ID: R9WI11 Facility ID: 012309 If continuation sheet Page 28 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
			B. WIN			02/12/	2013
			P. (VII		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	S.		1	TECHNOLOGY DR		
CROWN	POINTE OF CARMI	EL	CARMEL, IN 46032				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP		COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	-	DATE
R0349	410 IAC 16.2-5-8 Clinical Records (a) The facility must on each resident. maintained under employee of the fresponsibility. The follows: (1) Complete. (2) Accurately do. (3) Readily access (4) Systematically Based on recording the fresponsibility. The follows: (1) Complete. (2) Accurately do. (3) Readily access (4) Systematically Based on recording the fresponsibility. The follows: (1) Complete. (2) Accurately do. (3) Readily access (4) Systematically Based on recording the fresponsibility. The follows: (1) Complete. (2) Accurately do. (3) Readily access (4) Systematically Based on recording the fresponsibility. The follows: (1) Complete. (2) Accurately do. (3) Readily access (4) Systematically Based on recording the fresponsibility. The follows: (1) Complete. (2) Accurately do. (3) Readily access (4) Systematically Based on recording the fresponsibility. The follows: (1) Complete. (2) Accurately do. (3) Readily access (4) Systematically Based on recording the follows: (4) Systematically Based on recording the follows: (5) Accurately do. (6) Accurately do. (7) Accurately do. (8) Readily access (4) Systematically Based on recording the follows: (1) Complete. (2) Accurately do. (3) Readily access (4) Systematically Based on recording the follows: (1) Complete. (2) Accurately do. (3) Readily access (4) Systematically Based on recording the follows: (4) Systematically Based on recording the follows: (5) Accurately do. (6) Accurately do. (7) Accurately do. (8) Accurately do. (9) Accurately do. (9) Accurately do. (1) Complete. (1) Complete. (1) Complete. (2) Accurately do. (3) Readily access (4) Systematically Based on recording the follows: (1) Complete. (2) Accurately do. (3) Readily access (4) Systematically Based on recording the follows: (1) Complete. (2) Accurately do. (3) Readily access (4) Systematically Based on recording the follows: (4) Systematically Based on recording the follows: (5) Accurately do. (6) Accurately do. (7) Accurately do. (8) Accurately do. (9) Accurately do. (1) Complete. (1) Complete. (1	.1(a)(1-4) - Noncompliance ust maintain clinical records These records must be the supervision of an facility designated with that re records must be as cumented. sible. or organized. ord review and acility failed to have rentation of code status rents, and correct formation for 1 of 8 wed for documentation 8. (Resident #9, #13,	R03		1. The medical records of Residents # 13, #14, and #9 were reviewed and documentation updated to accurately reflect code status demographic information. 2. All residents have the potential to be affected, thus, a residents' medical records were audited to ensure the code stabirth date, and admission date were all correct on all docume throughout the charts. Corrections were made as needed. 3. Contracted healthcare services will be addressed to ensure that any change made regard to code status is communicated to the DON at time of said change. The DON designee will complete an auditool monthly ongoing to ensure the birth date, admission date, and code status are correct in medical record and on the rewrites. 4. As a means of quality assurance, the Administrator of the contract of the provided in the	all re atus, e nts in the l or lit e , the	02/28/2013

State Form Event ID: R9WI11 Facility ID: 012309 If continuation sheet Page 29 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			B. WING		02/12/2013
NAME OF E	PROVIDER OR SUPPLIEF	3	STRE	EET ADDRESS, CITY, STATE, ZIP CODE	
				10 TECHNOLOGY DR	
CROWN	POINTE OF CARM	EL	CAF	RMEL, IN 46032	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES.)	BE COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		d to have CPR (cardio		monitor to ensure the ongo	ng
	pulmonary res	uscitation).		audits are completed on a monthly basis ongoing. The	
				Administrator or designee v	
	The IDT (Inter	Disciplinary Team)		initial the form when review	
	Hospice Care	plan dated 12/28/12		Should a deficient practice	
	indicated the re	esident was a DNR.		observed, immediate correc	
				action will be taken. Based	•
	A request was	made of the Director of		the findings, the plan of cor will be revised accordingly,	
	Nursing (DON)	on 2/11/13 at 11:00		warranted.	"
	A.M., for the in	formation that is used			
	for the staff to	identify whether a			
resident is to be given CPR or if they					
	are a DNR.	3			
	The DON prov	ided a list of all of the			
		whether they were CPR			
		1/13 at 11:50 A.M. The			
		esident #13 was to			
	have CPR.	estacht // To was to			
	l llave of it.				
	In an interview	with the Director of			
		1/13 at 1:15 P.M., she			
	_	esident had been			
		a full code status to a			
		ce in December 2012.			
	1	a document titled "State			
		of Hospital Do Not			
		eclaration and Order"			
		2. She indicated she			
	was unaware t	his had been done.			
					
		record for Resident			
		ved on 2/11/13 at			
		agnoses included, but			
	were not limite	d to, dementia, high			

State Form Event ID: R9WI11 Facility ID: 012309 If continuation sheet Page 30 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	NSTRUCTION 00		TE SURVEY MPLETED	
			B. WING		- 02/	12/2013
	PROVIDER OR SUPPLIER		11610 T	ADDRESS, CITY, STATE, ZIP CO FECHNOLOGY DR EL, IN 46032	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
TAG	The document dated 8/10/12, was a DNR (do The document treatment, date resident wante pulmonary resident was a DNR. A request was Nursing (DON) A.M., for the infor the staff to resident is to b are a DNR. The DON proversidents and or DNR on 2/1 list indicated R.	e, and depression. ation on the face sheet indicated the resident o not resuscitate). ation on the choice of ed 6/1/11, indicated the ed to have CPR (cardio	TAG	DEFICIENCY		DATE
	Resident #9 wa 2/12/13 at 9:15 included, but wa neonatal ence	record review for as completed on 5 A.M. Diagnoses vere not limited to, phalitis, left sided sided weakness and e.				

State Form Event ID: R9WI11 Facility ID: 012309 If continuation sheet Page 31 of 42

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/12/2013
	PROVIDER OR SUPPLIE		11610 ⁻	ADDRESS, CITY, STATE, ZIP CODE TECHNOLOGY DR EL, IN 46032	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	indicated the r 1/28/13 and th was 3/22/55. The pre-place indicated the r was 8/22/55. The physician' February 2013 date of birth w admission date In an interview 2/12/13 at 2:00 the DNR statu Resident # 13	esident was admitted e residents birth date ment assessment form esident's date of birth s recapitulation for indicated the residents as 3/22/55 and the e was 3/30/12. With the DON on D.P.M., she indicated s was incorrect for and # 14 and the e and birth date for			

State Form Event ID: R9WI11 Facility ID: 012309 If continuation sheet Page 32 of 42

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
			B. WING		02/12/2013	
NAME OF I	PROVIDER OR SUPPLIER	.		ADDRESS, CITY, STATE, ZIP CODE		
CROWN	POINTE OF CARM	EL		TECHNOLOGY DR EL, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE DATE	
R0378	410 IAC 16.2-5-1	1.1(b)(1)(A-H)(2-3)				
		reening- Deficiency				
		al is a recipient of Medicaid				
	or federal Supple	mental Security Income				
		ual needs evaluation				
		on 2(a) of this rule shall				
		e limited to, the following: the individual for major				
	\ <i>'</i>	ich as a diagnosed major				
		limited to the following				
	disorders:	g				
	(A) Schizophrenia	a.				
	(B) Schizoaffectiv					
		r and major depressive				
	type) disorder.					
		lelusional disorder. r severe anxiety disorder.				
		or paranoid disorder.				
	(G) Personality di					
		hosis or other psychotic				
	disorder (not othe	erwise specified).				
		istory of treatment received				
	-	for a major mental illness				
	within the last two					
		istory of individual behavior o (2) years that would be				
		erous to facility residents,				
	the staff, or the in					
	· ·	view and record	R0378	1.Residents # 9 and	02/28/2013	
		ility failed to provide a		#29 have not exhibited		
		individual needs		problematic behaviors while		
	•	ich included a screen		residing in the facility and are		
	· ·	al illness, history of		being treated as ordered.		
		major mental illness		2.All current residents diagnoses were reviewed to		
		2 years, and a history		ensure that all residents with a	<u> </u>	
		ehavior within the last 2		major mental illness are received		
				necessary treatment, if		
	•	ld be considered		warranted. The prospective		
	_	he facility residents,		resident assessment (i.e.,		
		ual. This deficiency		pre-placement assessment) h		
	affected 2 of 5	residents receiving a		been revised to ensure all nev	V	

State Form Event ID: R9WI11 Facility ID: 012309 If continuation sheet Page 33 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPL	ETED
			A. BUI B. WIN			02/12/	2013
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹					
ODOMAN		- 1			FECHNOLOGY DR		
CROWN	POINTE OF CARM	EL		CARINE	EL, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Medicaid waive	er for payor status, in a			inquiries to the facility will have	e an	
		sidents. (Residents #9			assessment completed to inclu	ude	
	and #29)	olderito: (Iteolderito 110			screening for a major mental		
	anu #29)				illness.		
					3.The Director and DON will		
	Findings include	de:			be educated on the completion	n of	
					the Prospective		
	1. The clinical	record review for			Resident Assessment form,		
		as completed on			including the completion of the		
		5 A.M. Diagnoses			screening for major mental illn	ess	
		_			and necessary referral, if indicated.		
included, but were not limited to,					4.As a means of quality		
neonatal encephalitis, left sided					assurance the Administrator o	r	
	stroke with left	sided weakness and			designee will monitor to ensure		
	bipolar disease. The resident was				the Prospective Resident	C	
	admitted 1/28/	13.			Assessment has the questions	3	
					regarding major mental illness		
	The recident h	ad a pre-placement			completed, as appropriate,		
		rm dated 12/7/12. The			ongoing, The Administrator will	I	
					initial the form when reviewed.		
		the resident had a			Should a deficient practice be		
	diagnosis of bi	polar. There was no			observed, immediate correctiv	е	
	mention on this	s form regarding any			action will be taken.		
	behaviors, hos	pitalizations or					
	otherwise.	•					
	3.1.0.11100.						
	The short had	notes under the					
		notes under the					
		which contained					
	psychotherapy	notes for Resident #9.					
	The dates inclu	uded were: 9/10/12,					
	9/24/12, 10/15	/12, 10/22/12 and					
	11/12/12.	,					
	1 1/ 12/ 12.						
	The newsheath -	rony notoc provided					
		erapy notes provided					
		ent's prior skilled					
	nursing placen	nent indicated " was					
	seen for psych	otherapy for follow up					
		and physically					
	1						ĺ

State Form Event ID: R9WI11 Facility ID: 012309 If continuation sheet Page 34 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION 00	i í	TE SURVEY PLETED	
			A. BUILDING B. WING		- 02/1	2/2013
	PROVIDER OR SUPPLIER		STREET 11610	FADDRESS, CITY, STATE, ZIP CO O TECHNOLOGY DR MEL, IN 46032	ODE	
CROWNI (X4) ID PREFIX TAG	summary s' (EACH DEFICIEN REGULATORY OR aggressive beh documented to aggressive beh residents app increasing man appear to interi interpersonal ir agitation at this note indicated made verbally toward another to episode how indifferent to in behavioral resp expressed his in monitoring from There was no of screening or every #9 from the fact mental illness p In an interview Nursing on 2/1 indicated this w the facility had pertaining to as evaluation of re admission. She aware of the st with the mental	ratement of deficiencies cy Must be preceded by full lact identifying information) raviors. Patient show persistent raviors toward staff and rears to be showing ric symptoms which fere significantly with reactions and level of reme			IOULD BE	(X5) COMPLETION DATE

State Form Event ID: R9WI11 Facility ID: 012309 If continuation sheet Page 35 of 42

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/27/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/12/2013	
	PROVIDER OR SUPPLIER		11610 ⁻	ADDRESS, CITY, STATE, ZIP CODE TECHNOLOGY DR EL, IN 46032	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	#29 was review 12:20 P.M. The admitted on 1/2 that included, it diabetes, coror a pacemaker, of failure, and departments of the fortwo other consultant psycindicated she in that Resident them. She indicated the middle of the fortwo other consultant psycindicated she in that Resident in them. She indicated she indicated she she in	26/13 with diagnoses but were not limited to, hary heart disease with congestive heart bression. In needs evaluation, clude a screen for liness, a history of liness in the previous 2 story of any behaviors, 11:30 A.M., LPN #5 of current residents be from the facility chologist. She had started paperwork furrent residents to have by the psychologist, but #29 was not one of ficated Resident #29 tly receiving any			

State Form Event ID: R9WI11 Facility ID: 012309 If continuation sheet Page 36 of 42

STATEMENT OF DEFICIENCIES X1) PRO		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR		SURVEY			
AND PLAN OF CORRECTION IDE		IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED		
			B. WING			02/12/	02/12/2013	
					ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER					TECHNOLOGY DR			
CROWNPOINTE OF CARMEL					EL, IN 46032			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEI TELENCT)		DATE	
R0383	410 IAC 16.2-5-1	1.1(g)(1-2) reening - Deficiency						
	(g) The residentia	•						
		the mental health service						
	•	evelop the comprehensive						
	•	esident that includes the						
	following:							
		rehabilitation services that						
	•	d within the community.						
		sive range of activities to						
	following:	els of need, including the						
	-	and socialization activities.						
	(B) Social skills.	and decialization detivities.						
		upational, and work						
	programs.							
		for progression into less						
		ore independent living						
	arrangements.			0.0				
		view and record	R03	83	1.The Service Plans of		02/28/2013	
		ility failed to provide			applicable residents were updated to include pertinent diagnosis, interventions,			
		nd development of care						
	plans with men	tal health service			preferences, any need for mental			
	providers, for 3	of 5 residents			health services, and how the			
	reviewed for m	ental health care plans			residents needs will be met.			
	in a sample of	8. (Resident #9,			2.As all potential or current			
	Resident #50 a	and Resident #27)			residents have the potential to			
		,			affected, all new inquiries to the			
	Findings includ	le·			facility will have an assessmer completed to include screening			
	i iiiaiiigo iiioiaa				for a major mental illness, as v	-		
	1 The clinical	record review for			as all current residents with a			
	1. The clinical record review for Resident #9 was completed on 2/12/13 at 9:15 A.M. Diagnoses included, but were not limited to, neonatal encephalitis, left sided				major mental illness			
					identified. Should services be			
					necessary, the same shall be			
					sought. Any services shall be			
					addressed on the Service Plar	1 (0		
		sided weakness and			include pertinent diagnosis, interventions, preferences, any	V		
	•	e. The resident was			need for mental health service			
	admitted 1/28/	13.			and how the residents' needs			
				1				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED			
					02/12/	2013		
			B. WIN		DDDECC CITY CTATE ZID CODE			
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE			
ODOMANDONITE OF CADME!					ECHNOLOGY DR			
CROWN	CROWNPOINTE OF CARMEL			CARMEL, IN 46032				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	The resident has assessment for form indicated diagnosis of bit mention on this behaviors, hos otherwise. The chart had consultant tab psychotherapy The dates including 1/24/12, 10/15/11/12/12. The psychother from the resident nursing placem, " was seen follow up due to physically aggresistent aggr	ad a pre-placement rm dated 12/7/12. The the resident had a polar. There was no so form regarding any pitalizations or notes under the which contained a notes for Resident #9. Juded were: 9/10/12, 10/22/12 and erapy notes provided ent's prior skilled ment indicated 9/10/12 for psychotherapy for o verbally and ressive behaviors.			be met. 3. The Director and DON will be educated on the Pre-Placement Assessment for updates to include screening from a major mental illness, as well as required documentation on service Plans to ensure coordination of services. The DON or designee will review a update all service plans on a quarterly basis and as needed with changes. The DON or designee will complete an ongoing audit on a monthly basis of at least three (3) service plans to ensure all service plans are updated with current issue and interventions. 4. As a means of quality assurance the Administrator or designee will monitor to ensure the Pre-Placement Assessment form has the questions regard major mental illness completed and the Service Plan includes pertinent diagnosis, intervention preferences, any need for mer health services, and how the residents needs will be met monthly ongoing. The Administrator will initial the form when reviewed. Should a deficient practice be observed immediate corrective action will be taken. Based upon the monitoring, the plan of corrective warranted.	or s and asis as s as a s a s a s a s a s a s a		
		ver appeared indifferent						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A RIII	LDING	00	COMPL	ETED	
		B. WIN			02/12/	2013	
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					ECHNOLOGY DR		
CDOM/NDOINTE OF CADME!							
CROWN	CROWNPOINTE OF CARMEL			CARIVIE	EL, IN 46032		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES				PROVIDER'S PLAN OF CORRECTION		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE
	to inappropriate	eness of behavioral					
	response. Patie	ents expressed his					
		r the monitoring from					
	staff"	are memering nem					
	Stail						
	-	(;;; L Q ; D					
		titled "Service Plan,"					
	•	28, 2013, indicated					
		tinent diagnoses,					
	interventions, o	or social needs and					
	preferences. T	There was nothing					
	documented re	egarding a need for					
	mental health services and how they						
	were going to meet Resident #9's individual mental health needs.						
	iliulviduai illelii	iai neaith needs.					
		with the Director of					
		2/13 at 2:15 P.M., she					
	indicated this v	vas all the information					
	the facility had	on the resident for a					
	service plan. S	he indicated she was					
	•	e status of his meeting					
		I health service					
		frequency, or the date					
	•	. •					
	of the last visit.						
		record for Resident					
	#27 was reviewed on 2/12/13 at 9:45						
	A.M. Diagnose	es included, but were					
	not limited to, early congestive heart failure, history of colon cancer and diverticulitis, depression, psychotic episodes, right sided heart failure and						
		ure. The resident was					
	admitted on 6/3	3/2011.					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/12/2013			
NAME OF PROVIDER OR SUPPLIER CROWNPOINTE OF CARMEL			STREET ADDRESS, CITY, STATE, ZIP CODE 11610 TECHNOLOGY DR CARMEL, IN 46032					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		N		
	psychiatric seri 11/27/12, "se thoughts and obehaviorsno disturbances of documented in The document Needs/Service 7/26/12, with a 1/8/13. The se individual need (complete if reshealth diagnos) There was noth regarding a neservices and homeet Resident health needs. In an interview Nursing on 2/1 indicated this with facility had service plan. Se	recent behavioral r psychotic thinking are the chart" titled "Evaluation of Plan was dated revision date of ection noted at ls assessment sident has a mental is) was left blank. hing documented ed for mental health ow they were going to #27's individual mental with the Director of 2/13 at 2:17 P.M., she was all the information on the resident for a She indicated the history of psychotic to admission to the dicated she was not eatus of his meeting I health service frequency, or the date						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILDI		00	(X3) DATE S COMPL	ETED	
			B. WING			02/12/	2013
NAME OF PROVIDER OR SUPPLIER					DDRESS, CITY, STATE, ZIP CODE		
CROWNPOINTE OF CARMEL					ECHNOLOGY DR L, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID EFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	Resident #50 v 2/11/13 at 12:2 was admitted to with a Medicaid Diagnoses incl limited to, diabor morbid obesity disease, osteol incontinence, a and depression to a skilled num February, 2013 Reports from 1 indicated the re followed by psy another facility evaluation com indicated the re diagnoses of b and dementia. evaluation indic denied bipolar acknowledged history of leavin AMA (against r resident contin psychiatric follo following her ac CrownPointe.	O/7/11 and 11/14/11 esident had been ychiatric services in . A psychiatric npleted on 4/11/12 esident also had ipolar disease, anxiety, A note in the cated the resident disease but depression, and had a ng previous facilities medical advice). The ued to receive					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/12/2013			
NAME OF PROVIDER OR SUPPLIER CROWNPOINTE OF CARMEL			STREET ADDRESS, CITY, STATE, ZIP CODE 11610 TECHNOLOGY DR CARMEL, IN 46032					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	OULD BE COMPLET	ΓΙΟΝ		
	Review" page	ervice Plan Record of indicated the Service reviewed on 7/26/12, /13/13.						
	the mental head did not address rehabilitation s within the component comprehensive meet multiple I recreational an activities, social training/occupa or opportunities less restrictive living arrangen In an interview A.M., LPN #5 i listing the men	e range of activities to evels of need including ad socialization al skills, potential ational/work programs, s for progression into and more independent						

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